Rhode Island Commission on Women

Position Paper on Cancer

Cancer is second only to heart disease as the leading cause of death in women. In the last decade, the national overall cancer incidence and deaths have shown a steady decline. However, this is not reflected in the experience of women to the same degree in Rhode Island.

The excess burden of cancer for women in Rhode Island is clearly demonstrated by the increased incidence and increased risk of death for breast, colorectal and lung cancer reported recently by the National Cancer Institute.[1] (See Table 1.) This can be associated with an aging population, the state's location in the Northeast Industrial Corridor, and its largely urban setting with its associated lifestyle.

Cancer is a disease of older people, increasing in frequency with increasing age. Over 50% of all cancers occur in individuals over the age of 65. Contributing to the burden of cancer is the fact that the population of women in Rhode Island is older than the national average. There are approximately 50% more women between the ages of 65 and 84 in Rhode Island than the national average and almost twice the proportion of women over the age of 85.[2]

Lifestyle contributes to an increase in cancer incidence and mortality. Tobacco is the leading cause of preventable deaths from cancer. The last decade has seen a sustained decrease in lung cancer in men because of a continuing lower smoking rate. Similar decreases have not as yet been seen in women. In 1999, 21% of women smoked cigarettes regularly and an equal number were former smokers and/or exposed to second hand smoke.[3]

A high-fat diet appears to increase the risk for breast cancer and colon cancer. In 1999, 42% percent of women in Rhode Island were overweight.[3] Although the vast majority of women have had a routine checkup within the last year, 60% of women over the age of 50 have never had any tests for colorectal cancer. Since screening will remove pre-malignant colon lesions, the lack of screening for colorectal cancer in women over the age of 50 contributes to a 16% higher incidence of colorectal cancer than the national average. For these women, the lack of removal of these pre malignant lesions and any early cancers that may have formed leads to a 7.5% higher death rate.[1]

While 80% of women under 60 report having had an annual mammogram, older women, who are at a higher risk, have a mammography rate of only approximately 50%.[4] (Women who do not go for their mammograms are not likely to have a Pap smear and are more likely to be smokers.[5]) Eighty-five percent of women in Rhode Island report that they have had a Pap smear within the last year. However, this high figure is not seen in the Hispanic or African-American populations. (African-American women make up approximately 4% of the female population and Hispanics are approximately twice that number.) The aggregate effect contributes to Rhode Island's poor cancer experience.

Inadequate access to health care is a major barrier to appropriate cancer detection, prevention, and treatment. Approximately 7% of Rhode Island's population is uninsured[6] and a somewhat larger number are underinsured. Rhode Island's RIteCare program provides health care for the Medicaid-eligible population. The uninsured and underinsured population report 42% not having a routine checkup, 81% never having had any colorectal cancer screening, 19% not having a Pap smear, and 31% not having a mammogram in two years. Thirty-six percent smoke cigarettes regularly.[2,7]

Work schedules, difficulties with child care and transportation, and language are barriers to screening among low income women. Low income, working single mothers may find the hours of facilities such as Community Health Centers to be a barrier. Cultural differences may also lead minority groups to utilize health care in different ways. Hispanic women and some groups of Southeast Asian/Pacific Islander women may be less likely to participate in mam-

mography and Pap smear programs because in their cultural history, the requirements for such screening may be viewed as a serious invasion of personal privacy[8, 9, 10, 11, 12]. For elderly women, transportation problems may prevent them from seeking medical attention.

Older women have yet another problem. The type of treatment recommended to them for a diagnosed cancer may be less complete and/or intense than would be recommended to a younger woman. Age discrimination contributes to decreased participation in clinical trials.[13] Recommendations for post-mastectomy radiation and/or chemotherapy have been shown to be significantly less for women over the age of 65 than under the age of 65, regardless of their physiological status.[14, 15]

Support programs to improve access to health care may not be available to all women who need them. For women with disabilities and for women for whom English is not a first language, health care facilities without barriers and with multilingual staff are needed. For many women, regardless of their ethnic status, navigating through the health care system can be an overwhelming experience. They may need psychosocial support throughout the course of their illness and beyond.

With the growing number of cancer survivors, there is a need to examine the cancer burden faced by survivors as they recover from treatment. Furthermore, their attempts to resume their societal roles may be impeded by job and insurance discrimination. Lifestyle changes among cancer survivors such as stopping smoking or losing weight may help to reduce risk of future cancers.[16] The goal of primary prevention of cancer may also be advanced when their family members make similar lifestyle changes.

The RICW recommends the following goals for women's health care:

1. Improve cancer literacy so that women will know the importance of lifestyle and health checks for cancer prevention, detection, and cure.
2. Address cultural and ethnic disparities, including women with disabilities, to improve access and utilization of health care for the detection and treatment of cancer.
3. Overcome age discrimination in the management of cancer in women.
4. Provide support programs for all women, including working mothers, women with disabilities, and other women who may need psychosocial support. "Navigators" who assist women throughout the detection, treatment, and overall care of cancer can help women overcome many of the barriers to improved health care.

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Table 1

RHODE ISLAND WOMEN - CANCER BURDEN, 1994-1998

JNCI 93(11):824-842, 2001

	Breast	Colorectal	Lung
Incidence - RI*	117.0	44.0	53.8
National	111.6	38.0	46.6
Difference (%)	+4.8	+15.8	+15.5
Deaths - RI *	26.6	14.7	37.9
National	23.8	13.7	34.9
Difference (%)	+10.8	+7.3	+8.6

*per 100,000 age corrected to 1970 data

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